DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/09/12

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44A114	A. BUILDING _____ B. WING _____	10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure staff provided proper cleansing to prevent possible urinary tract infections for one resident (#8) of sixteen residents reviewed. The findings included: Resident #8 was admitted to the facility on June 11, 2010, with diagnoses including Alzheimer's with Behaviors, Depression, Osteoarthritis, and Hypothyroidism. Medical record review of the Minimum Data Set dated October 9, 2012, revealed the resident was frequently incontinent of the bladder and was totally dependent for toileting and personal hygiene care. Medical record review of the resident's care plan dated October 17, 2012, revealed "...assist with peri care after each incontinent episode..."	F 315	1. On 10/30/12, a review of the medical record for Resident #8 per administrative nursing staff does not indicate any symptoms or current treatment for urinary tract or other infection. On 10/30/12, the Resident was placed on alert charting to observe for any signs or symptoms of urinary infection. An education packet, including the policy for perineal care and infection control/standard precautions, was initiated for all nursing staff on 10/30/12. All nursing staff shall receive and review packet by 11/8/12. All new nursing employees shall receive packet on hire date. 2. On 10/29/12, a review of current medication regimens per administrative nursing staff reveals that no current treatments for urinary tract infections are in place for any resident. 3. CNT observations of perineal care were initiated on 10/30/12 by licensed nursing staff. Observations will continue with 4 per week for one week, then 2 per week for 3 weeks, then one per week for 4 weeks. Additional education will be provided at time of observation, if needed. 4. DON, or designee, will monitor for compliance. Review will be made during quarterly QA meeting with QA committee to assess need for ongoing performance improvement programs.	11/16/2012

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Trevett

TITLE: Administrator

(X6) DATE: 11/08/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 315	Continued From page 1 Observation on October 24, 2012, at 9:35 a.m., in the resident's room, revealed Certified Nursing Technician (CNT) #1 performing pericare on the resident. CNT #1 washed the hands and applied protective gloves, applied a gait belt to the resident and then transferred the resident to the bed, removed the gloves to retrieve additional supplies to perform pericare, and without washing hands left the resident's room. CNT #1 returned to the resident's room and without washing the hands applied protective gloves. CNT #1 then resumed pericare on Resident #8 by first cleansing the rectal area of stool and then without changing gloves and washing hands cleansed the labia without separation. CNT #1 then removed the gloves and without washing hands applied a gait belt to the resident to aid with transfer to the resident's wheelchair. Review of facility policy entitled "Perineal Care", not dated, revealed "...wash perineal area, wiping from front to back...separate labia and wash area downward from front to back..." Review of facility policy entitled "Handwashing/Hand Hygiene", not dated, revealed "...employees must wash their hands...before and after direct resident contact...after removing gloves...hand hygiene is always the final step after removing and disposing of personal protective equipment..." Interview with CNT #1 on October 24, 2012, at 10:05 a.m., outside the resident's room, confirmed the resident was cleaned from back to front, the hands were not washed and gloves were not changed after cleaning the rectal area,	F 315		

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F 315	Continued From page 2 and the gait belt was applied to the resident before CNT #1 washed the hands.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to evaluate and implement an intervention to reduce the risk of accidents. The findings included: During the group meeting with the residents on October 23, 2012 from 2:30 p.m. until 3:20 p.m., in the Activity Room, one resident revealed the men's and women's restrooms located across from the Activity Room, and next to the Dining Room, on the first floor of the facility, were not equipped with emergency pull cords. Continued interview during the group meeting, revealed the residents were concerned they would be unable to call for help if the residents were not able to be heard through the restroom doors. Observation of the men's and women's restrooms on the first floor of the facility on October 23, 2012, at 3:45 p.m., revealed neither restroom was equipped with a method of alerting staff from the	F 323	1. On 10/24/12, pull alarms were placed in both restrooms in question. 2. On 10/30/12, resident areas of the facility were monitored by the Administrator for potential accident risks, with no areas identified. 3. Telephones to enable contact with the nursing station will be installed in both restrooms in question. 4. During the next three Resident Council meetings, the facilitator will ask the members if there are areas in the facility that they are concerned about regarding safety or access. After that time, the same will be addressed annually during Resident Council meetings. Results of this questioning will go to the QA Committee for further action.	11/16/2012

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F 323	Continued From page 3 inside of the restroom by the residents. Interview with the Director of Nursing (DON) on October 24, 2012, at 8:25 a.m., in the DON's office, confirmed the absence of emergency pull cords in the restrooms located on the first floor of the facility. Interview with the Administrator on October 24, 2012, at 1:20 p.m., in the Administrator's Office, confirmed the absence of emergency pull cords, or other call system, in the restrooms on the first floor of the facility. Continued interview confirmed the residents of the facility also utilized the restrooms during times when staff members were not present on the first floor. Continued interview confirmed the lack of emergency pull cords in the restrooms presented a risk to the resident's safety.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 328		

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F 328	Continued From page 4 and interview, the facility failed to ensure oxygen was administered at two liters per nasal cannula for one resident (#10) of sixteen residents reviewed. The findings included: Resident #10 was admitted to the facility on November 18, 2008, with diagnoses including Dementia, Diabetes, Impaired Renal Function, Cerebrovascular Accident, and Anemia. Medical record review of the Minimum Data Set dated July 16, 2012, revealed the resident was severely cognitive impaired, had short and long term memory problems, and required total assistance with transfers and all activities of daily living. Medical record review of a Physician Order dated October 22, 2012, revealed, "O2 (Oxygen) at 2L (two liters) PNC (per nasal cannula) PRN (as needed) (Decrease O2 SATS (oxygen saturation), SOB (shortness of breath)" Observation on October 22, 2012, at 8:00 p.m., in the resident's room, revealed the resident lying in bed with oxygen infusing per nasal cannula at five liters per minute. Interview with the Director of Nursing on October 22, 2012, at 8:15 p.m., at the nursing station, confirmed the resident's oxygen was infusing at five liters per minute and the Physician's Orders had not been followed.	F 328	1. On 10/22/12, Resident #10 was assessed by LPN and DON. The Resident was having an acute change in status and was experiencing symptoms of CHF exacerbation. LPN had used nursing judgment and increased oxygen flow rate while waiting for response from Resident's physician. LPN obtained order to titrate the oxygen to try to stabilize oxygen saturation. 2. All residents receiving oxygen therapy were audited on 10/22/12 by nursing administration to ensure the correct flow rate, per physician order, was in place. The following order was added to the physician's routine orders: May administer oxygen via nasal cannula or facial mask for oxygen saturations less than 91% or shortness of breath. May titrate oxygen to maintain oxygen saturations at or above 91%. Oxygen saturations every shift. Notify MD if oxygen is administered. 3. DON, or designee, will review all new oxygen orders to ensure correct flow rate is in place, per MD order, for 90 days. 4. DON will present for review during quarterly QA meeting. The QA committee will determine if ongoing monitoring is needed.	11/16/2012
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary storage of food and equipment. The findings included Observation of the dietary department on October 22, 2012, from 7:25 p.m. until 8:40 p.m., revealed: 1. Open and not dated 32 ounce container of blue food coloring, and was available for use; 2. Open and not dated 28 ounce container of lemon pepper seasoning, and was available for use; 3. The toaster had debris on top of it and was stored on a shelf with clean coffee cups; and was available for use; 4. Two wire food cooling racks were stored with debris on them, and were available for use; 5. Salad bar utensils, measuring cups, and ladles were stored in plastic containers with debris in the bottom of them, and were available for use; 6. Eight drinking glasses were stored wet, and were available for use;	F 371	#1 and #2 1. The food coloring and seasoning were dated on 10/22/12 since they had been opened that day. 2. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. Dietary staff was in-serviced regarding the need to date all opened items. The cooks will be responsible to check all items for label & date at the end of each shift. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the labeling of opened items during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring. #3 1. The toaster was cleaned by the dietary staff on 10/23/12. 2. Dietary equipment will be maintained in a sanitary manner. 3. A new toaster has been purchased to replace the toaster in question. The new toaster will be added to the daily cleaning schedule. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the toaster during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	11/16/2012 11/16/2012

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F 371	Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary storage of food and equipment. The findings included Observation of the dietary department on October 22, 2012, from 7:25 p.m. until 8:40 p.m., revealed: 1. Open and not dated 32 ounce container of blue food coloring, and was available for use; 2. Open and not dated 28 ounce container of lemon pepper seasoning, and was available for use; 3. The toaster had debris on top of it and was stored on a shelf with clean coffee cups; and was available for use; 4. Two wire food cooling racks were stored with debris on them, and were available for use; 5. Salad bar utensils, measuring cups, and ladles were stored in plastic containers with debris in the bottom of them, and were available for use; 6. Eight drinking glasses were stored wet, and were available for use;	F 371	#4 1. The racks in question were de-limed and cleaned by dietary staff on 10/23/12. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. The racks were placed on a regular cleaning schedule by dietary staff. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the racks during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring. #5 1. The container and contents in question were discarded on 10/22/12. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. The containers to be used will be cleaned by dietary staff on a regular cleaning schedule. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the plastic containers during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	11/16/2012 11/16/2012

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F 371	Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary storage of food and equipment. The findings included Observation of the dietary department on October 22, 2012, from 7:25 p.m. until 8:40 p.m., revealed: 1. Open and not dated 32 ounce container of blue food coloring, and was available for use; 2. Open and not dated 28 ounce container of lemon pepper seasoning, and was available for use; 3. The toaster had debris on top of it and was stored on a shelf with clean coffee cups; and was available for use; 4. Two wire food cooling racks were stored with debris on them, and were available for use; 5. Salad bar utensils, measuring cups, and ladles were stored in plastic containers with debris in the bottom of them, and were available for use; 6. Eight drinking glasses were stored wet, and were available for use;	F 371	#6 1. The glasses in question were rewashed on 10/22/12. 2. Dietary equipment will be maintained in a sanitary manner. 3. Glass storage trays, which will allow for air circulation during drying time, have been purchased and dietary staff is being in-serviced regarding their use. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the drying process for glasses during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring. #7 1. The steam table pans in question were rewashed on 10/22/12. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. On day shift, all pans will be given at least 5 hours to dry before storing and overnight for the closing shift 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the steam table pans during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	11/16/2012 11/16/2012

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F 371	Continued From page 6 7. Five steam table pans were stored wet, and were available for use; 8. Serving trays and baking pans were stored with debris and dust on them on a shelf with clean coffee cups, and were available for use. Interview with the head cook and the dietary department manager on October 22, 2012, at 8:40 p.m., in the dietary department, confirmed the food coloring and the lemon pepper seasoning were to have been dated when opened. Continued interview, at that time, confirmed the toaster, wire cooling racks, and serving trays and pans were to be cleaned before being stored in a clean area and all utensils, measuring cups, and ladles were to be properly stored in clean containers; drinking glasses, and steam table pans were to be dried prior to being stored for use. Continued observation on October 24, 2012, at 8:05 a.m., in the dietary department, revealed a circulating fan on a pedestal in the on position and blowing over a food prep area. Interview with the dietary manager on October 24, 2012, at 8:08 a.m., in the dietary department, confirmed "you can't have a fan blowing over food."	F 371	#8 1. The serving trays from outside functions were discarded on 10/22/12. 2. Dietary equipment will be maintained in a sanitary manner. 3. Serving trays from outside functions will not be stored in the kitchen area in the future. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the presence of trays from outside functions during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	11/16/2012
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	#9 1. The fan was removed from the kitchen area on 10/24/12. 2. Dietary equipment will be maintained in a sanitary manner. Food will be stored, prepared and distributed at all times under sanitary conditions. 3. Use of pedestal fans will not be allowed in the kitchen area. 4. This corrective action will be monitored by the department CDM, CFPP. The RD will check the use of pedestal fans during her monthly department rounds. When no issues are identified for 3 consecutive months, the RD will cease this monitoring.	11/16/2012

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F 441	Continued From page 7 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure staff cleansed the over bed table prior to placing clean supplies on it, failed to ensure staff washed hands during a dressing	F 441	1. On 10/29/12, medical records for Residents #8 and #2 were reviewed by administrative nursing staff. No current treatments for infections are in place or signs/symptoms of urinary tract or other infections are noted for above stated residents. On 10/24/12, hand washing check-off sheets were initiated with nursing staff. Observations are to be conducted by nursing administrative staff. On 10/29/12, nursing administrative staff began observations for hand washing during medication pass or treatments. On 10/30/12, observations for perineal care were initiated by licensed nursing staff. 2. On 10/29/12, education was initiated for nursing staff including infection control and hand washing. All nursing staff will have received and reviewed education packets by 11/8/12. All new nursing employees will receive and review education packet on hire date. 3. Nursing administrative staff will observe 4 times a week for one week, then 2 times a week for 3 weeks, then once a week for 4 weeks, with additional training provided as needed at the time of observation. 4. The DON, or designee, will monitor results each week. The QA Committee will review on next quarterly meeting to determine if continued performance improvement programs are needed.	11/16/2012

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F 441	Continued From page 8	F 441		

change for one resident (# 2), failed to ensure staff washed hands and changed gloves during incontinence care for one resident (#8), and failed to ensure staff maintained infection control practices during a medication administration for sixteen residents reviewed.

The findings included:

Observation on October 23, 2012, at 1:30 p.m., revealed the facility's treatment nurse performing a dressing change on resident's (#2) right heel. Observation revealed the treatment nurse placed a clean barrier on the over bed table and placed the clean supplies on the barrier without cleansing the table. Observation revealed the treatment nurse washed the hands, applied gloves, removed the old dressing from the right heel, and discarded the dressings in a plastic bag. Continued observation revealed the treatment nurse cleansed the wound, measured the wound, and applied a clean dressing to the right heel without removing gloves or washing the hands.

Continued observation of the treatment nurse performing the dressing change on the resident's left heel revealed the treatment nurse washed the hands, applied gloves, removed the old dressing from the left heel, and discarded the dressings in a plastic bag. Continued observation revealed the treatment nurse cleansed the wound, measured the wound, and applied a clean dressing to the left heel without removing gloves or washing the hands.

Review of the facility's Wound Care Policy revealed, "...Put exam glove. Loosen tape and

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	44A114	A. BUILDING _____ B. WING _____	10/25/2012

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F 441	Continued From page 9 remove dressing. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. Put on gloves..." Interview with the treatment nurse on October 23, 2012, at 2:00 p.m., at the nursing station, confirmed the over bed table was not cleansed prior to applying a clean barrier and the hands were not washed between cleansing the wound and applying a clean dressing for both heels. Resident #8 was admitted to the facility on June 11, 2010, with diagnoses including Alzheimer's with Behaviors, Depression, Osteoarthritis, and Hypothyroidism. Medical record review of the Minimum Data Set dated October 9, 2012, revealed the resident was frequently incontinent of the bladder and was totally dependent for toileting and personal hygiene care. Medical record review of the resident's care plan dated October 17, 2012, revealed "...assist with peri care after each incontinent episode..." Observation on October 24, 2012, at 9:35 a.m., in the resident's room, revealed Certified Nursing Technician (CNT) #1 performing pericare on the resident. CNT #1 washed the hands and applied protective gloves, applied a gait belt to the resident and then transferred the resident to the bed, removed the gloves to retrieve additional supplies to perform pericare, and without washing hands left the resident's room. CNT #1 returned to the resident's room and without washing the hands applied protective gloves. CNT #1 then resumed pericare on Resident #8 by first	F 441		

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F 441	Continued From page 10 cleansing the rectal area of stool and then without changing gloves and washing hands cleansed the labia. CNT #1 then removed the gloves and without washing hands applied a gait belt to the resident to aid with transfer to the resident's wheelchair. Review of facility policy entitled "Handwashing/Hand Hygiene", not dated, revealed "...employees must wash their hands...before and after direct resident contact...after removing gloves...hand hygiene is always the final step after removing and disposing of personal protective equipment..." Interview with CNT #1 on October 24, 2012, at 10:05 a.m., outside the resident's room, confirmed the hands were not washed and gloves were not changed after cleaning the rectal area, and the gait belt was applied to the resident before CNT #1 washed the hands. Observation during Medication Administration on October 23, 2012, at 8:55 a.m., revealed Registered Nurse (RN) #1 preparing medications for Med Pass Resident A. Continued observation revealed RN #1 dropped a pill from the original packaging onto the top surface of the medication cart. Further observation revealed RN #1 picked up the medication from the cart using a paper medication cup, carried the medication in the cup into the resident's room, donned a pair of gloves, returned to the medication cart and placed the medication with gloved hand into the resident's medication cup for administration. Interview with RN #1 on October 23, 2012, at 9:00 a.m., outside the resident's room, confirmed	F 441		

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F 441	Continued From page 11 RN #1 was going to administer the medication after the medication had been dropped on the surface of the medication cart. Continued interview confirmed RN #1 would administer the medication because "it did not touch the floor". Further interview with RN #1 confirmed the top surface of the medication cart was not clean. Continued observation during Medication Administration with RN #1 on October 23, 2012, at 9:05 a.m., outside Resident A's room, revealed RN #1 placed Resident A's medication in a locked drawer, entered the resident's room to wash her hands and returned to the medication cart. Continued observation revealed RN #1 unlocked the drawer to the medication cart, removed the resident's medications, closed the drawer, picked up the water pitcher to pour water into a seperate cup, picked up the medications, knocked on the resident's door, placed the medications on the resident's bedside table, and without rewashing her hands, administered PO medications to the resident. Further observation revealed RN #1 then donned a pair of gloves located in the resident's room, picked up a container of eye drops, and then administered eye drops in the resident's eyes without washing hands before or after the administration of the eye drops. Review of facility policy, entitled "Handwashing/Hand Hygiene", not dated, revealed handwashing is required "...5c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)...", and "...8. The use of gloves does not replace handwashing/hand hygiene..." Continued review of facility policy revealed, "...7. Hand	F 441		

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F 441	Continued From page 12 hygiene is always the final step after removing and disposing of personal protective equipment..." Interview with RN #1 on October 23, 2012, at 9:10 a.m., outside the resident's room, confirmed RN #1 did not follow proper infection control practices during medication administration to the resident.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to maintain a resident call system in the men's and women's restrooms utilized by the residents on the first floor of the facility. The findings included: During the group meeting with the residents on October 23, 2012 from 2:30 p.m. until 3:20 p.m., in the Activity Room, one resident revealed the men's and women's restrooms located across from the Activity Room and next to the Dining Room, on the first floor of the facility, were not equipped with emergency pull cords. Continued interview during the group meeting revealed the residents were concerned they would be unable to call for help if the residents were not able to be heard through the restroom doors.	F 463	1. On 10/24/12, pull alarms were placed in both restrooms in question. 2. On 10/29/12, resident areas of the facility were monitored by the Administrator for potential accident risks, with no areas identified. 3. Telephones to enable contact with the nursing station will be installed in both restrooms in question. 4. During the next three Resident Council meetings, the facilitator will ask the members if there are areas in the facility that they are concerned about regarding safety or access. After that time, the same will be addressed annually during Resident Council meetings. Results of this questioning will go to the QA Committee for further action.	11/16/2012

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F 463	Continued From page 13 Observation of the men's and women's restrooms on the first floor of the facility on October 23, 2012, at 3:45 p.m., revealed neither restroom was equipped with a method of alerting staff from the inside of the restroom by the residents. Interview with the Director of Nursing (DON) on October 24, 2012, at 8:25 a.m., in the DON's office, confirmed the absence of emergency pull cords in the restrooms located on the first floor of the facility. Interview with the Administrator on October 24, 2012, at 1:20 p.m., in the Administrator's Office, confirmed the absence of emergency pull cords, or other call system, in the restrooms on the first floor of the facility. Continued interview confirmed the residents of the facility also utilized the restrooms during times when staff members were not present on the first floor. Further interview confirmed the lack of emergency pull cords in the restrooms presented a risk to the resident's safety.	F 463		